

# Future of Consumer Directed Healthcare:



## 2015 Public Health Nurses Conference

*April 29, 2015*

*Valle Vista Golf Club – Greenwood IN*

*John J. Wernert, MD*

*Secretary*

*Family and Social Services Administration*



# Today's presentation

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- ✓ Consumerism in Healthcare
  - Who pays for healthcare?
  - Managed Consumerism
- ✓ Move to CDHP's - Indiana's Experience
- ✓ How HIP 2.0 works
- ✓ Provider reimbursement
- ✓ Future of Payment Models

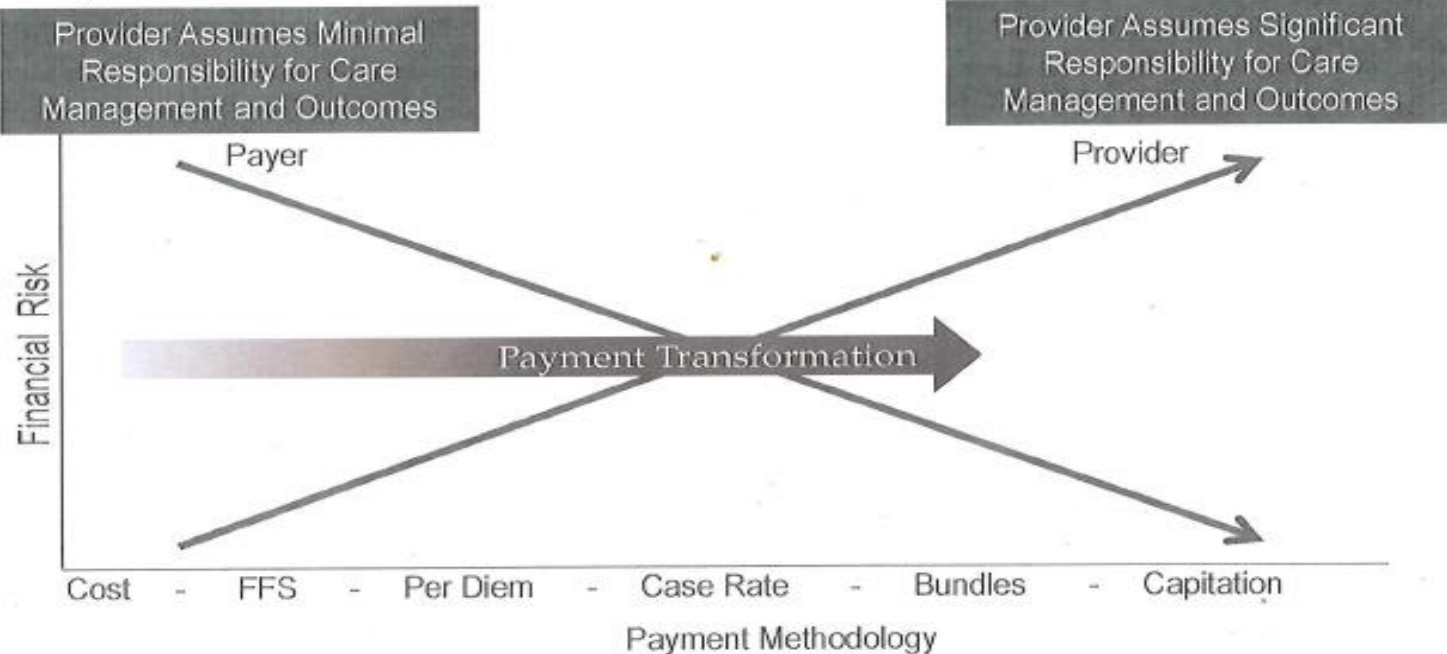
# Compensation Models

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- ✓ Bartering
- ✓ Fee For Service
- ✓ Growth of Indemnity Insurance (price insensitive)
- ✓ Capitation (Managed Care)
- ✓ HSA/MSA
- ✓ Episode of Care (Bundled Payments)
- ✓ Accountable Care Organizations (ACOs)
- ✓ Concierge Models

## Bundled Payment Models

### Payment Transformation Steps



# Healthcare Consumerism:

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- ✓ Movement which advocates patient involvement in their own HC decisions
- ✓ Culture of choice
- ✓ Move from “ Dr Says/Pt Does” to partnership
- ✓ Involves transfer of knowledge so that pt can be informed and make individualized choices
- ✓ Who pays? Move from “incentivized” 3<sup>rd</sup> party to consumer-directed payments

# Why focus on consumerism in HC payments?

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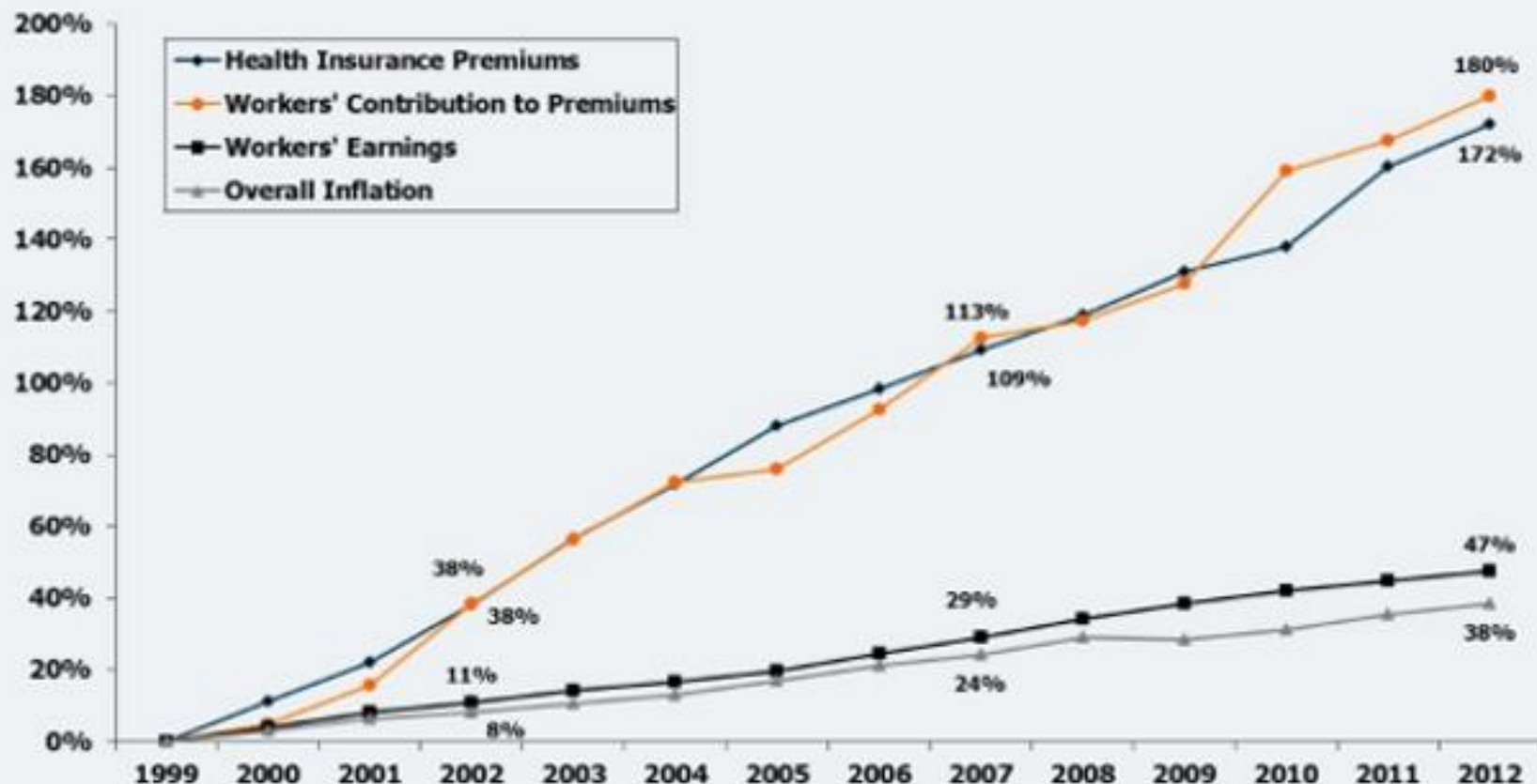
- ✓ 15.5 million Americans have high-deductible health plans
- ✓ 75% of consumers surveyed said they were confused by the US Healthcare system
- ✓ 1.7M Americans declare “medical “ bankruptcy (#1 cause)
- ✓ In 2010 - \$65 B written off by providers due to pt's bad debt - increasing at 30% rate
- ✓ HC industry does not successfully set payment expectations or deliver flexible ways to pay
  - Providers struggling to collect
  - Consumers dissatisfied

## Example – EOB's

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- ✓ Consumers receive an EOB from payer that states:
  - *“DO NOT PAY”*
  - *“THIS IS NOT A BILL”*
- ✓ Weeks or months later, consumers receive a bill from various providers - which is a bill - and often only offers a paper-based, unclear payment option

## Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).



# Managed Consumerism in Healthcare:

## THE DIFFERENCE BETWEEN PATIENTS AND CONSUMERS

	<b>Patients</b>	<b>Consumers</b>
Level of engagement in decisions about their treatments	Low: depend on physicians to make decisions on their behalf	High: depend on physician recommendation and personal verification
Level of awareness of treatment options and associated costs	Low: depend on physician opinion	High: depend on online tools and social media
Source of trust in providers they use	High: based on personal experiences and word-of-mouth	High: based on personal experiences and comparison shopping
Primary unmet needs	Access within a reasonable timeframe + personal attention	Value: access + service delivery + outcomes + cost
Unmet need from insurance plan sponsor	Large networks of providers to enhance access and convenience + manageable out-of-pocket costs	Narrow networks of high-performing (high-value) providers + predictable costs

Robinson, James; 10.1377/hlthaff.24.6.1478 Health Aff November 2005 vol. 24 no. 6 1478-1489

# The Promises of Consumerism

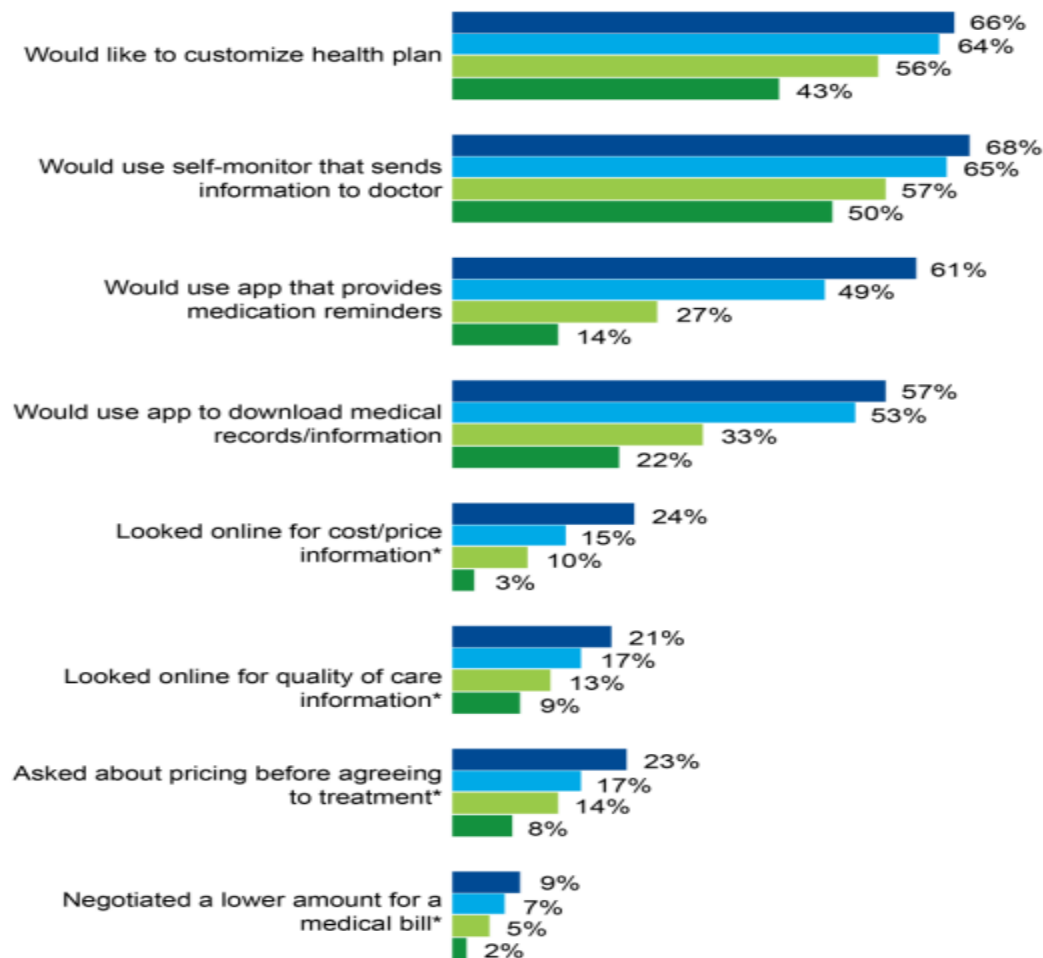
## Major Building Blocks of Consumerism



It is the creative development, efficient delivery, efficacy, and successful integration of these elements that will prove the success or failure of consumerism.

# Generational Differences

Source: Deloitte Center for Health Solutions Consumer Survey, 2012



■ Millennials (ages 18-30) ■ Gen X (ages 31-47)  
 ■ Boomers (ages 48-66) ■ Seniors (ages 67+)

\*Percentage of consumers reporting one or more illnesses or injuries

# What is consumer-driven health care?

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- ✓ Consumer-driven health care (CDHC) plans
  - high deductible health plans (HDHP's) +
  - health savings accounts (HSAs) or similar products
  - Consumers pay for initial health care expenses or deductibles.
- ✓ The high-deductible health plan (HDHP) protects patients from catastrophic medical expenses, while the deductible exposes them to the costs of their care and engages them to manage their use of services appropriately.
- ✓ The design is referred to as "consumer-driven health care" because basic and routine costs are paid by the patient-managed account versus the insurance company.
- ✓ This promotes consumerism by giving patients greater control over their own health budgets and the health care they receive.
- ✓ The use of CDHPs fosters competition in the marketplace as patients become active consumers and providers compete to provide services, lowering prices and increasing

# Why is the State using a consumer-driven model?

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- ✓ The State of Indiana has a long history of success with the consumer-driven health care model.
- ✓ Indiana ranks highly among states in consumers covered by high deductible health plans attached to Health Savings Accounts.
- ✓ Studies show that employer adoption of the consumer-driven model considerably decreases total health care spending.
- ✓ Consumer-driven plans are also popular among employees. About 96 percent of Indiana state employees have voluntarily elected to enroll in a consumer-driven health plan option.
- ✓ In its first four years of offering consumer-driven health plan options to state employees, the State has saved 10.7 percent annually, as employees used hospital emergency departments at lower rates, had fewer physician office visits, lower prescription costs and a higher generic medication dispensing rate.

# Medicaid Expansion

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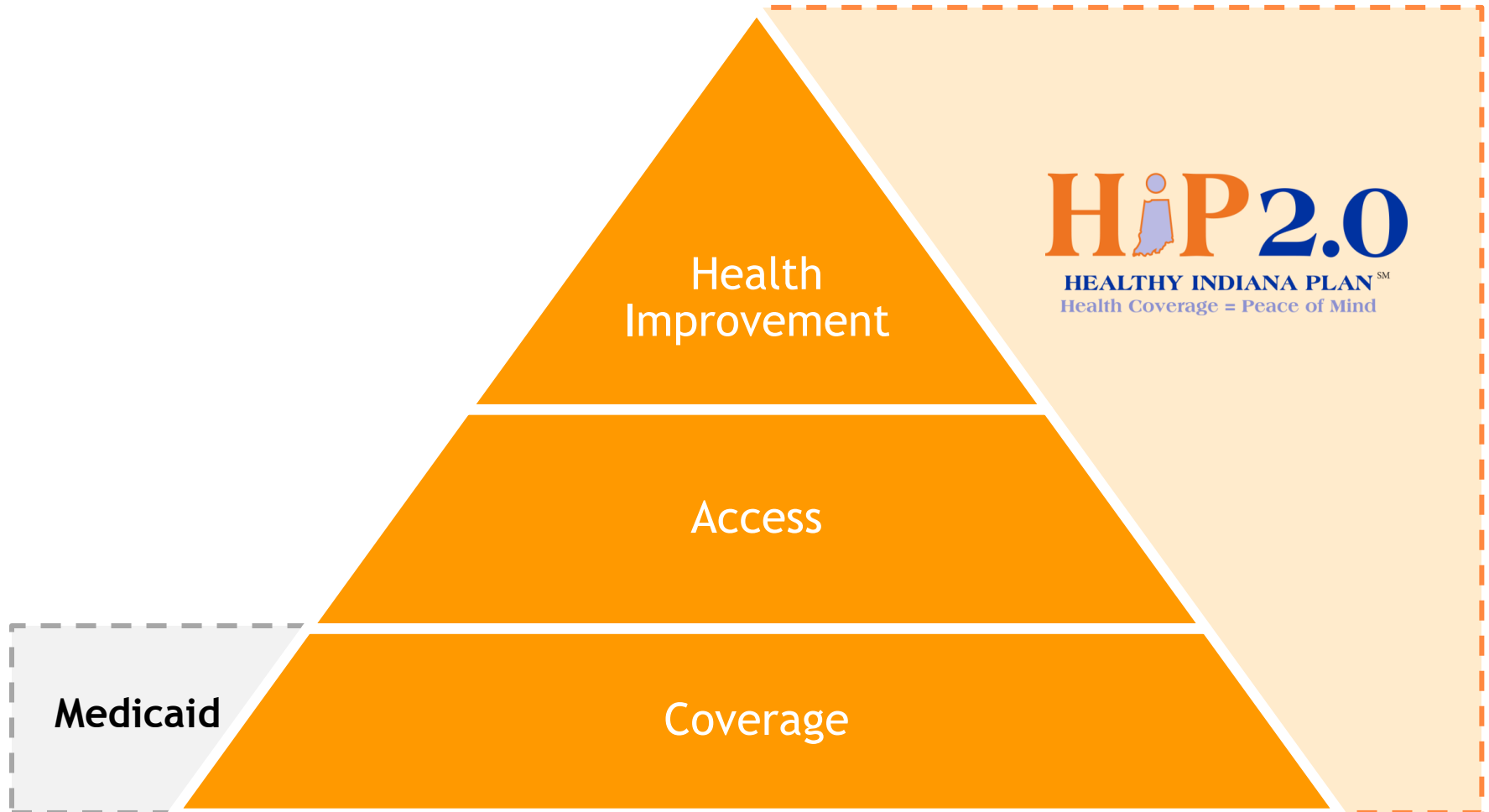
- ✓ ACA
- ✓ Supreme Court Decision - can't force states to expand Medicaid
- ✓ President's Challenge
- ✓ Allow states to be “incubators:
  - Chart own path
  - Establish own priorities
  - Devise own solutions
- ✓ Entice states with 100% federal match 1<sup>st</sup> 3 years
- ✓ 26 states + DC took \$ - traditional Medicaid expansion

# Problems with Traditional Medicaid:

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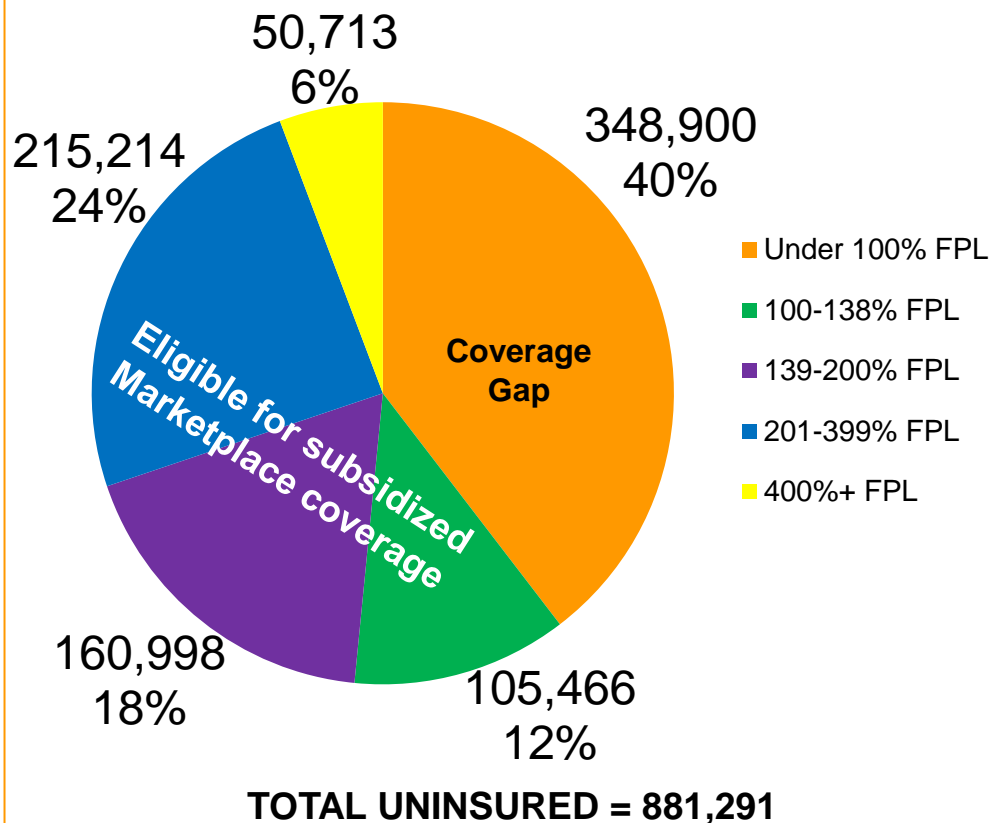
- ✓ Income-based entitlement
- ✓ Out-dated Model
  - No co-pays/deductibles/co-insurance
  - No repercussions for no-show or non-compliance
  - Minimal choice
- ✓ Low incentives to “get healthy”
- ✓ Provider reimbursement doesn’t cover cost of care
- ✓ Poor access - Dwindling provider network
- ✓ Escalating costs with poor outcomes

# HIP 2.0 vs. Medicaid Expansion



# State of the Uninsured in Indiana

## Uninsured Hoosiers, 2010<sup>1</sup>



## How do the Federal Poverty Levels translate to annual income? - 2013

FPL <sup>2</sup>	Individual	Family of 4
Under 100%	< \$11,490	< \$23,550
100-138%	\$11,490-15,970	\$23,550-32,734
139-200%	\$15,971-23,094	\$32,735-47,335
201-399%	\$23,095-45,959	\$47,336-94,199
400%+	> \$45,960	> \$94,200

Indiana Uninsured: 13.6% in 2010

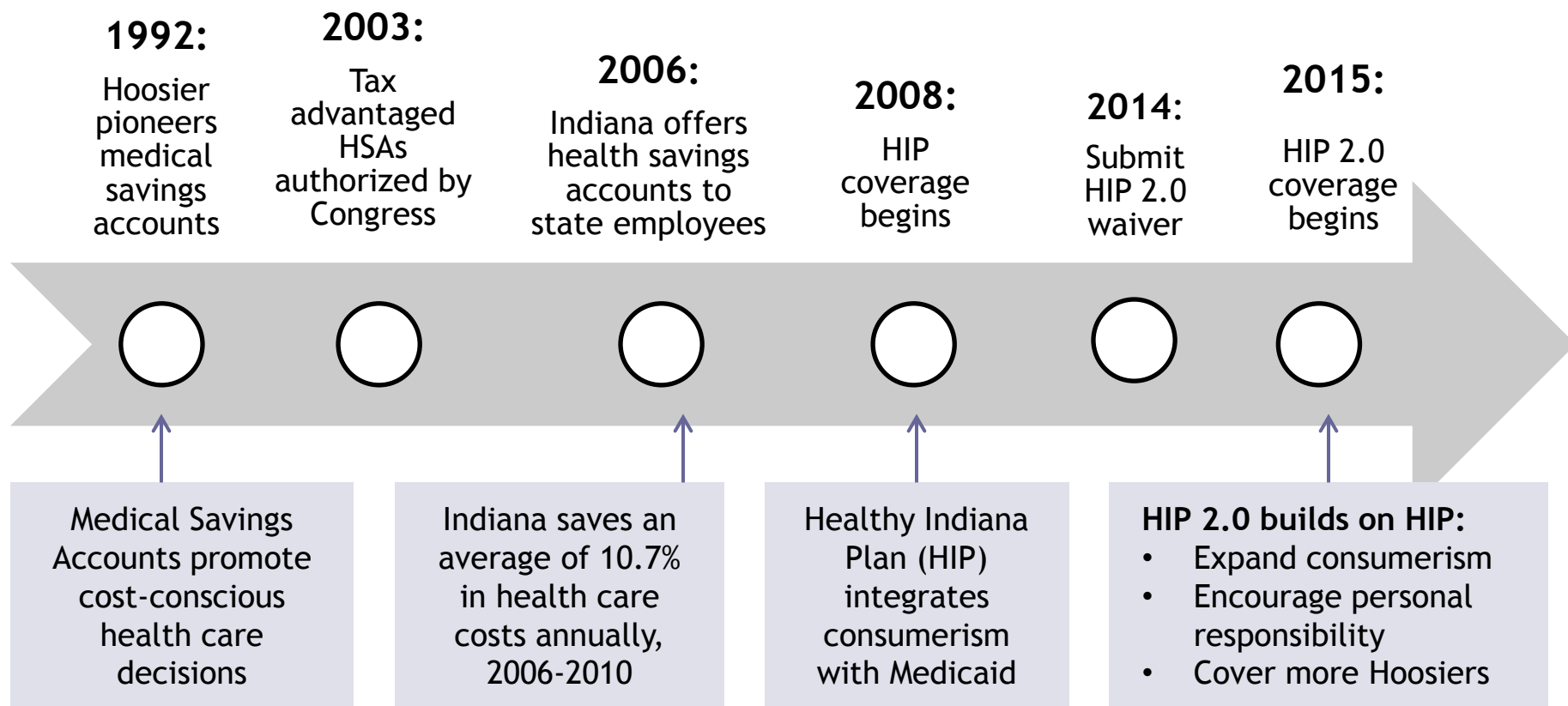
1. SHADAC Health Insurance Analysis. (2011). American Community Survey data. Retrieved from [www.nationalhealthcare.in.gov](http://www.nationalhealthcare.in.gov).  
 2. Office of the Assistant Secretary for Planning and Evaluation. (2013). 2013 Poverty Guidelines. Retrieved from <http://aspe.hhs.gov/poverty/13poverty.cfm>.

# NUMBER OF HOOSIERS RECEIVING BENEFITS

<b>Enrollees by Program (as of June 30 annually)</b>										
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>Medicaid</b>	847,625	857,599	877,933	920,332	1,017,571	1,088,637	1,110,188	1,127,015	1,160,979	1,187,565
<b>Food Stamp Recipients</b>	557,206	575,602	586,156	639,470	721,155	828,604	887,851	911,071	926,166	883,308
<b>Food Stamp Households</b>	241,177	249,914	253,443	273,876	306,562	355,626	388,271	405,219	418,362	402,479
<b>TANF</b>	141,055	135,206	117,311	122,743	119,912	104,004	69,906	39,374	29,715	23,595
<b>Number of Hoosiers enrolled in at least one program*</b>	<b>899,701</b>	<b>922,434</b>	<b>943,343</b>	<b>1,013,429</b>	<b>1,114,950</b>	<b>1,250,774</b>	<b>1,295,799</b>	<b>1,324,689</b>	<b>1,339,057</b>	<b>1,335,755</b>

\* Program totals are comprised of only unique cases, not a sum of individual program data.

# Hoosier Innovation: Health Savings Accounts



**In 2013, 420,000 Hoosiers were enrolled in HSAs.  
This represents 9% of insured individuals –  
higher than the national average.**

# HIP Success

## HIP improves health care utilization

Lowers inappropriate emergency room use by 7% compared to traditional Medicaid

60% of HIP members receive preventive care - similar to commercial populations

80% of HIP members choose generic drugs, compared to 65% of commercial populations

## HIP results in high member satisfaction

96% of enrollees satisfied with HIP coverage

83% of HIP enrollees prefer the HIP design to co-payments in traditional Medicaid

98% would enroll again

## HIP promotes personal responsibility

93% of members make required POWER account contributions on time

30% of members ask their healthcare provider about the cost of services

# HIP 2.0 Structure

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- ✓ Replaces traditional Medicaid for non-disabled adults
- ✓ Three pathways to coverage
  - **HIP Link:** NEW defined contribution plan that helps pay for employer-sponsored health insurance
  - **HIP Plus:** Current program with enhanced benefits including dental and vision
    - Reduced non-payment lock-out period: 6 months instead of 12 months
    - Only option for individuals above 100% FPL
  - **HIP Basic:** Allows individuals below 100% FPL who do not make POWER account contributions to maintain coverage

# How is HIP 2.0 different?

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- ✓ □ Maintains and increases the value of the POWER account for all members. The POWER account is the Health Savings Account that members use to pay for their deductible.
- ✓ □ Eliminates enrollment caps in HIP, so that any person under 138 percent of the federal poverty level is eligible for HIP.
- ✓ □ Provides a new option for families to be covered by the same health plan.
- ✓ □ Provides a new HIP Employer Benefit Link plan that supports participation in employer-sponsored insurance plans.
- ✓ □ Institutes new, affordable, required contributions for all members.
- ✓ □ Creates a significant value proposition for Hoosiers below the federal poverty level, rewarding those that contribute to their POWER accounts with access to the “HIP Plus” plan, an enhanced benefit plan that covers dental and vision care.
- ✓ □ Individuals who choose not to make contributions to their POWER accounts will maintain coverage through the HIP Basic plan, a more limited health benefits plan.
- ✓ □ Promotes independence from public assistance by connecting unemployed HIP members with job training and search programs.

# HIP Plus: POWER Account Contributions

- ✓ POWER account contributions are approximately 2% of member income
  - Minimum contribution is \$1 per month\*
  - Maximum contribution is \$100 per month (individual enrollee in a 9 person household earning \$62,000/year)
- ✓ Employers & not-for-profits may assist with contributions
  - Employers and not-for-profits may pay up to 100% of member PAC
  - Ideally, payments are made by individual directly to member's selected managed care entity
- ✓ PAC amount based on family income
- ✓ If spouses both enrolled, they split the monthly PAC amount

\*Approximately 20% of HIP eligible population will have an income the corresponds with the minimum \$1 PAC

# HIP Plus: POWER Account Contributions

## Monthly POWER account contribution examples\*\*

FPL	Monthly Income/PAC Individual	Monthly Income/PAC Household of 4**
22%	\$216 = \$4.32	\$445 = \$8.90
50%	\$491 = \$9.82	\$1,010 = \$20.22
75%	\$736 = \$14.72	\$1,516 = \$30.32
100%	\$981 = \$19.62	\$2,021 = \$40.42
138%	\$1,369 = \$27.39	\$2,822 = \$56.44

\*Amounts can be reduced by other Medicaid or CHIP premium costs

# Ways to Pay the POWER Account Contribution



- ✓ Regardless of health plan members can pay by:
  - Credit or debit card (including prepaid cards)
    - Over the phone
    - Online
  - Check or money order
  - Automatic bank draft
  - Electronic funds transfer
  - Payroll deduction
  - Cash, at one of the following locations:

Anthem	MHS	MDwise
Pay at any Wal-Mart	Pay by Western Union <i>Coming soon:</i> Pay at any Wal-Mart	Pay at a Fifth Third Bank <i>Coming soon:</i> Pay at any Wal-Mart

# HIP 2.0 Eligibility

Who is  
eligible for  
HIP 2.0?

- **Indiana residents ages 19 to 64**
  - income **under 138%** of the federal poverty level (**FPL**)
  - who are not eligible for Medicare or otherwise eligible for Medicaid
- **Includes individuals previously enrolled in:**
  - Healthy Indiana Plan (HIP 1.0) (61,000)
  - Hoosier Healthwise (HHW) (120,000)
  - Parents and Caretakers (MAGF)
  - 19 and 20 year olds (MAT)

# HIP 2.0 Coverage

When does  
service coverage  
begin?

- February 1, 2015
- HIP & applicable HHW members converted to HIP 2.0 without having to reapply
- New applicants may submit Indiana health coverage application and be considered for HIP coverage

What types of  
services are  
covered?

- **HIP Basic:**
  - Minimum Essential Coverage providing the Essential Health Benefits
- **HIP Plus:**
  - HIP Basic benefits with additional services including bariatric surgery, TMJ treatment, and more allowed physical, speech and occupation therapy visits
  - Vision
  - Dental

# Transition to HIP 2.0

Who provides  
services to HIP  
2.0 members?

- Eligible Providers must enroll as Indiana Health Care Provider with Indiana Medicaid and...
- Must enroll with Managed Care Entity (MCE) to provide in-network services to HIP members
- All HIP members will have a Primary Medical Provider (PMPs)

Who pays  
for services?

- **Risk-based MCEs**
  - Anthem
  - MDWise
  - Managed Health Services (MHS)

\*Does not include emergency service providers

# Transition to HIP 2.0

How will  
members be  
placed in a MCE?

- Current members will stay with current MCE
- New members select MCE
  - On application OR
  - Call enrollment broker after application OR
  - Auto-assigned by HP

How should one  
answer member  
questions?

- Refer members to their MCE
  - Anthem: (866) 408-6131
  - MDWise: (800) 356-1204
  - MHS: (877) 647-4848

# HIP 2.0 Gateway to Work

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- ✓ All individuals who complete the application for HIP coverage will be connected to job training and job search programs offered by the State of Indiana
- ✓ Voluntary Program - DWD collaboration
- ✓ ***“Doesn’t make it harder to get benefits, it makes it easier to get a job!”***

# Cost-sharing

HIP Basic members required to pay co-payment for services<sup>1, 2</sup>

Provider verifies if member must pay co-payment when checking eligibility

Provider should collect all co-payments at time of service<sup>3</sup>

Payment to provider will be reduced by amount of copayment

1. Member does not pay co-payment after 5% of household income spent on out-of-pocket health care costs
2. Pregnant women and Native Americans exempt from cost-sharing
3. Provider cannot deny service based on member inability to pay

# Co-payment Amounts – HIP Basic

Service	HIP Basic Co-Pay Amounts ≤100% FPL
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-preferred drugs	\$8
Non-emergency ED visit	Up to \$25 <sup>*</sup>

*\*\$8 for first non-emergent emergency department (ED) visit; \$25 for any additional*

# HIP Reimbursement Rate Increases

- In HIP all benefit packages pay at
  - Medicare rates *or*
  - 130 percent of Medicaid rates
  - HIP Basic reimbursement reduced by copay amount
- In Medicaid (Hoosier Healthwise/pregnancy/kids and aged, blind and disabled)
  - INCREASED rates by an average of 25 percent
    - BH = 85% MC
    - Prenatal/Maternity = 100% MC

# New/Proposed E/M reimbursement structure

Procedure/code	Current Medicaid (Non Facility)	HIP/HIP 2.0	New “legacy” Medicaid (Non Facility)*
EGD biopsy single/multiple/ 43239	\$181.60	\$377.05	\$282.78
Office visit (new)/99203	\$47.44	\$102.28	\$76.71
Office visit (established)/99213	\$31.96	\$69.32	\$51.99
Initial hospital care/evaluation/99222	\$80.67	\$132.80	\$99.60
ER visit/99283	\$43.82	\$59.78	\$44.84
Cataract removal/66984	\$550.51	\$630.34	\$472.75
Chest x-ray 2 view/71020	\$25.03	\$29.13	\$21.85
EKG/93000	\$20.63	\$15.78	\$11.84

\* These proposed rates are subject to change after final determination of rate methodology.

- Goal is to increase Medicaid aggregate payment at least 15%
- Some codes go down, most go up
- Net total new Medicaid reimbursement to be around 75% Medicare

# Maintaining Financial Sustainability

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**HIP 2.0  
will be  
sustainable  
& will not  
increase  
taxes for  
Hoosiers**

HIP 2.0 will continue to utilize HIP Trust Fund dollars

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HAF - Indiana hospitals will help support costs to expand HIP 2.0 starting in 2017

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Waiver specifies HIP 2.0 continuity requires:

- Enhanced federal funding
- Hospital assessment program approval

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# Projected HIP Enrollment

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Year	Projected “total” enrollment
2015	356,869
2016	518,506
2017	544,763
2018	552,390

# Program Rollout Update

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- ✓ Since Governor Pence announced HIP 2.0 on January 27:
  - Program began same day as announcement
  - **170,000+** immediately enrolled in HIP 2.0
  - Over **200,000** new applications received for health coverage - over 81% have been received online
  - Approx. **145,000** newly eligible approved
  - Our DFR and GET-HIP9 call centers have received over 150,000 HIP calls
  - Over 24,000 letters sent to Hoosiers receiving health coverage from the Federal Marketplace to inform them about HIP 2.0 health coverage
  - Nearly 1,000 new providers, including 335 physicians have joined the network
  - Statewide meetings and events continue with providers and other stakeholder groups
- ✓ Advertising campaign to come (June 2015)

## In summary: HIP 2.0...

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- ✓ Is Indiana-specific solution
  - Establishes our own priorities
  - Builds off of successful program
- ✓ Expands coverage AND improves access
- ✓ Consumer-directed (ownership)
  - Price transparency
  - Patient/provider partnership
  - Focus is on outcomes

# We need your help!

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known and economic are  
important for the people  
of the people need to  
**education** more  
purchase new goods like  
phones, some of them  
with out money and

Questions?